Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Original Public Report

Report Issue Date: October 16, 2024

Inspection Number: 2024-1494-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Ukrainian Home for the Aged

Long Term Care Home and City: Ivan Franko Home (Etobicoke), Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16-20, and 23-24, 2024

The following intake was inspected during this Critical Incident (CI) Inspection:

- Intake: #00111996 - CI #C530-000006-24 was related to Falls Prevention and Management Program

The following intake was completed in this complaint inspection:

- Intake: #00116461 was related to Food and Nutrition, responsive behaviours, improper care and medication administration.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a fall prevention equipment that was set out in a resident's plan of care, was provided to the resident.

Rationale and Summary

A resident's care plan indicated that they were at risk of fall, and required to have a fall prevention equipment in place. During an observation the fall prevention equipment was not functioning.

A Registered Nurse (RN) acknowledged the fall prevention equipment was not functioning and stated it should have been functional. The Director of Care (DOC) confirmed that all the fall prevention interventions should have been provided to the resident as indicated in their care plan.

Failure to provide fall prevention equipment to the resident as set out in their care plan may put them at risk of injury following any fall incident in future.

Sources: The resident's clinical records, an observation of the resident, interviews with an RN and the DOC.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with post-fall management processes for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to have a written description of the falls program that includes its goals, objectives, procedures and protocols, and must be complied with.

Specifically, staff did not comply with the home's policy "Falls Prevention and Management Program", which was indicated that "When a resident has fallen, if it is safe to do so, the resident may be carefully assisted off the floor/moved, ensuring that proper lifting procedures with a 2-person lift using a mechanical lift are followed".

Rationale and Summary

A resident had a fall in a designated area which resulted in injury. The resident's clinical records indicated that a Registered Practical Nurse (RPN) and Personal Support Workers (PSWs) who found the resident on the floor, transferred them to their room without using a proper lifting equipment.

The RPN confirmed that following the fall incident the resident was not able to weight bear, however was transferred to their room without using proper lifting equipment. The DOC indicated that following the fall incident with injuries, the resident should have been transferred to their room utilizing a proper lifting equipment, that was consistent with the home's falls prevention and management policy.

Failure to follow the home's policy and utilize proper lifting procedure post-fall poses an increased risk of injury.

Sources: The resident's clinical records, interviews with a RPN, and the DOC, the home's "Falls Prevention and Management Program" policy (NM-I-042).

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that two PSWs used proper and safe feeding techniques when assisting two residents with feeding.

Rationale and Summary

Observation of lunch indicated that two PSWs were feeding two residents who required feeding assistance, while standing.

The home's "Feeding Instructions" policy, indicated that "staff should always feed residents in sitting position and at their eye level."

The two PSWs, both confirmed that they should have been seated when they were feeding the two residents. The DOC indicated that all staff who were feeding residents were supposed to be seated and at the same level as the residents to safely feed them. They also confirmed that the two PSWs should have been sitting at all times when feeding residents.

Failure to use proper feeding techniques with residents may put them at risk of aspiration with their meal.

Sources: Observation of lunch in one of the home areas, interviews with two PSWs, a RPN and the DOC, home's Feeding Instructions policy, DM-A-022(a).